

CLAIM VERIFICATION SYSTEM

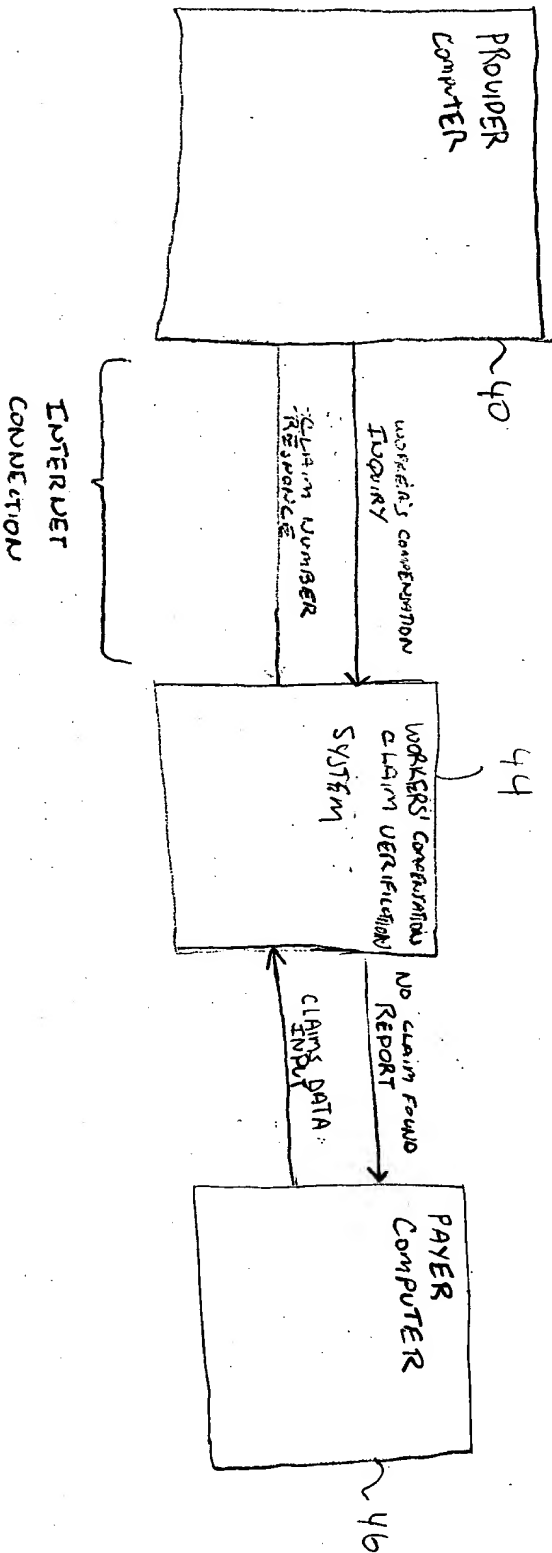


FIGURE 1

PROVIDER USING SOFTWARE
PROGRAM SENDS AN
ELECTRONIC INQUIRY
REQUEST ACROSS INTERNET
TO CLAIM VERIFICATION
DATABASE SYSTEM

50

52 ~
? CLAIM IN
DATABASE?
NO
YES

54 ~
CLAIM VERIFICATION DATABASE
SYSTEM AUTOMATICALLY
SENDS INDICATION OF
WORKERS' COMPENSATION
CLAIM NUMBER TO
PROVIDER

56 ~
PROVIDER CAN NOW
PROVIDE REPORTS FOR
PAYER CONTAINING CORRECT
WORKERS' COMPENSATION
CLAIM NUMBER

CLAIM VERIFICATION DATABASE
SYSTEM AUTOMATICALLY
SENDS REPORT TO
PAYER

56

PAYER PROMPTS EMPLOYER
TO REPORT INJURY

58

FIGURE 2

WORKER'S COMPENSATION
MEDICAL TREATMENT REPORTING

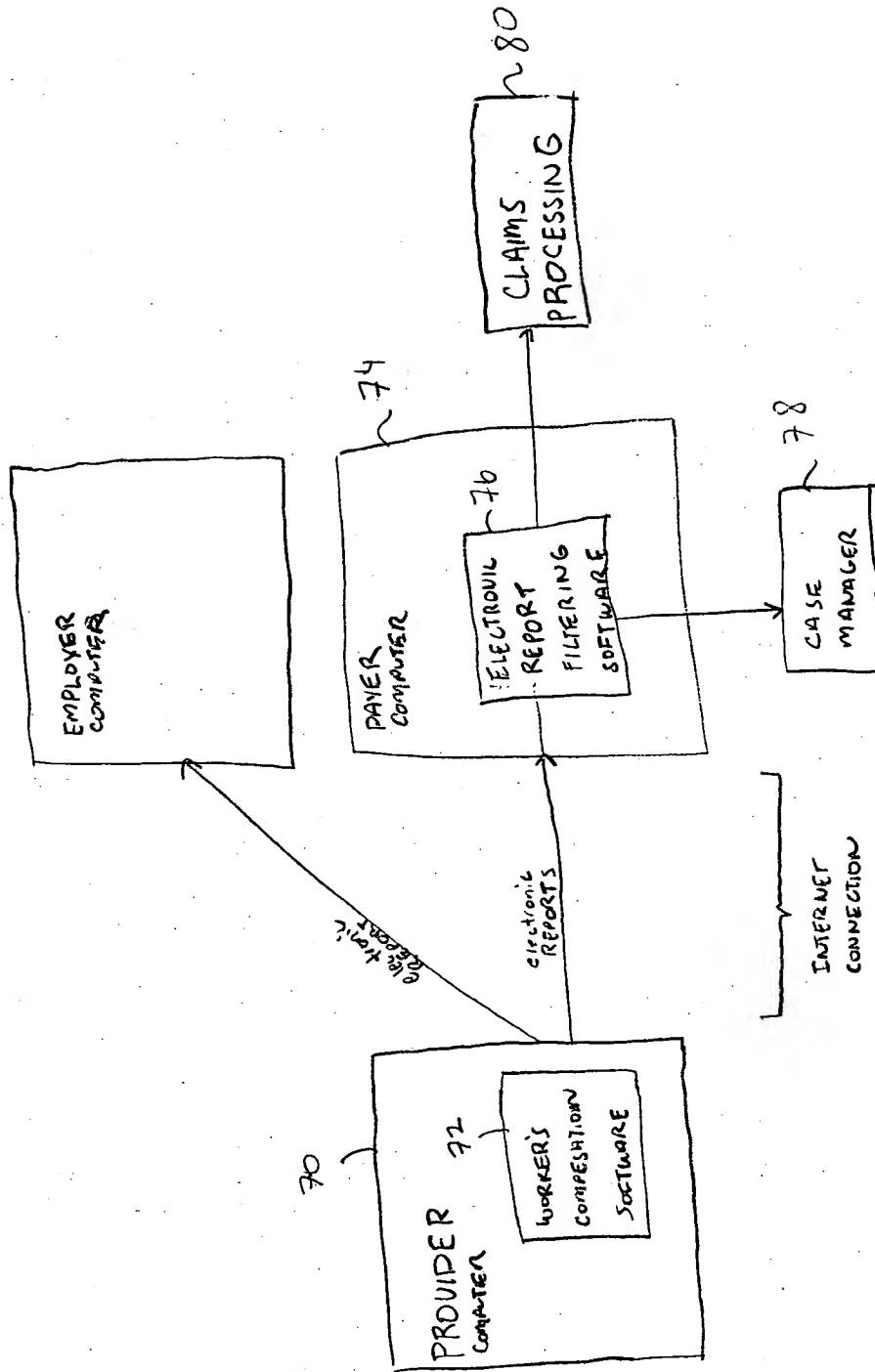


FIGURE 3

PROVIDER FILLS OUT REPORT FORM
USING SOFTWARE; FORM CONTAINS
ALL REQUIRED DATA FIELDS ~90

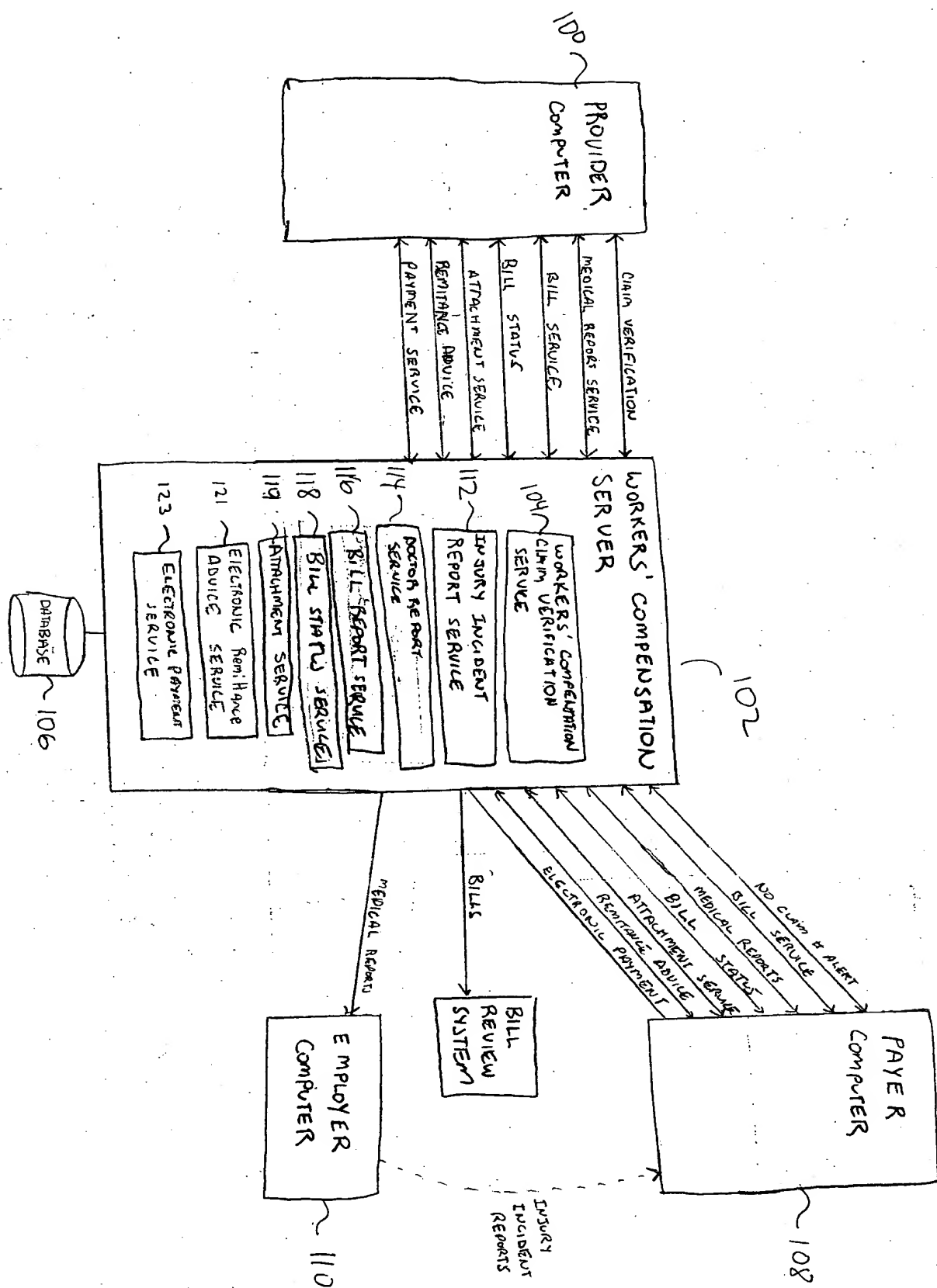
ELECTRONIC REPORT SENT TO
PAYER ~92

SOFTWARE AT THE PAYER
EXAMINES THE ELECTRONIC
REPORT TO AUTOMATICALLY
SELECT REPORTS TO SEND TO
A CASE MANAGER ~94

SELECTED REPORTS SENT TO
CASE MANAGER FOR HUMAN
REVIEW ~96

FIGURE 4

FIGURE 5



First Report (Input Form)

Main Forms Entry Employment Reports Workers' Compensation Reports E-Mail New Patients Evidence Tables Administration Help



| Patient | History | Findings | Diagnosis | Treatment | Work Status | User Fields |
|--|---------|----------|-----------|-----------|-------------|-------------|
| Patient Information: LName ANDERSON FName JIM SSN# 494-94-9494 DOB 10/16/1999 Report Date: 10/21/1999 | | | | | | |
| Injury Information: 12. Injured at Address 234 CONTRA COSTA BLD City CONCORD State CA Zipcode 94549-3003 County CONTRA COSTA 13. Date and hour of injury or onset of illness: 10/16/1999 08:00 AM PM 14. Date Last Worked: 10/16/1999 15. Date and hour of first examination or treatment: 10/17/1999 03:00 AM PM 16. Have you (or your office) previously treated patient? Yes No 16a. Treated under any health plan for this incident? Yes No 16b. Health Plan Name: BLUE CROSS | | | | | | |
| 17. Patient's Description of how the Accident or Exposure Occurred: A. Description: LIFTING A 40# PRODUCE BOX FROM THE FLOOR, WHEN I FELT SHARP BACK PAIN B. Relevant Past History: RECURRENT LUMBAR/SACRAL STRAINS C. Description of present occupational duties: Heavy Lifting D. Relevant leisure activities: WEEKEND FOOTBALL, SKIING, SAILING E. Does employee have 2nd job? Yes No If yes, Employer Name: MT ROSE SKI RESORT | | | | | | |

for Workers' Compensation

Save OK Yskale View Print OK to Send Suspended Delete Cancel

Doctor's First Report

Start StellarForm5021 - Microsoft

StellarNet Worker's Compensation

Date and Time: 10/21/99 10:11:01 AM

10:18 AM

FIGURE 6

Report Page 1

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Page 1 of 2

STATE OF CALIFORNIA
Form DSHL 61099
RISK FIRST CASE

Form ID: INS000010000002

1. INSURER NAME AND ADDRESS

INSURER: 123 COAST DRIVE, SAN FRANCISCO, CA 94107
Telephone Number: 415-339-3939

1b. Citation #

REPORT DATE
10/17/1999

2. EMPLOYER NAME

EMPLOYER: 204 MARINA WAY
SAN LEANDRO, CA 94589-0904
Telephone Number: 510-393-0593

3. Address No and Street
4. City
5. State
6. Zip
7. Date of Birth
8. Sex
9. Home Tel #
10. Work Tel #

5. PATIENT NAME

PATIENT: JIM ANDERSON

8. Address

1744 BELLE VALLEY RD
LAFAYETTE, CA 94508-8888
11a. Social Security #
11b. Date of Hire
11c. Patient Account #

10. Occupation (check job)

JOURNEYPERMANENT CLERK

12. Injured At

204 CONTRA COSTA BLD

13. Date and hour of Injury

10/16/1999 08:30 AM

14. Date and hour of first examination or treatment

10/17/1999 09:00 AM

15. Date and hour of last examination or treatment

10/17/1999 09:00 AM

16. Treated under any Health Plan for the Insured?

Yes ☐ No ☐ If Yes, Health Plan Name: BLUE CROSS

17. PATIENT'S DESCRIPTION OF HOW THE ACCIDENT OR EXPOSURE OCCURRED:

A. Description: LIFTING A BOX FROM THE FLOOR, WHEN I FELT SHARP BACK PAIN

B. Relevant Past History: RECURRENT LUMBOSACRAL STRAINS

C. Description of Present Occupational Duties:

D. Relevant Leisure Activities: WEEKEND FOOTBALL, SKIING, SAILING

E. Does Employer have Job?

Yes ☐ No ☐ If Yes, Employer Name: MT ROSE SKI RESORT

18. SUBJECTIVE COMPLAINTS:

A. Description: SHARP LOW BACK PAIN

B. Symptoms:

Body Part: Lower Back
Onset: Sudden
Quality: Sharp
Frequency: Constant
Severity: Moderate
Preexisting Activities: Lifting/Driving/Office

19. OBJECTIVE FINDINGS:

A. Vital Signs:

HR: 120
BP: 120/80
Wt: 190
Pulse: 78
Temp: 98.5
Resps: 18
Ain

B. Focused Physical Exam:

40 DEGREES LUMBAL FLEXION WITH POSITIVE RIGHT STRAIGHT LEG RAISE AT 60 DEGREES

C. X-Ray and Laboratory Results:

NONE

D. Job Description Reviewed:

Yes ☐ No ☐ If Yes, explain:

20. DIAGNOSIS:

A. Description: STRAIN LUMBOSACRAL
C. Chemical Or Toxic Component Involved? Yes ☐ No ☐ If Yes, explain:
D. Other Relevant Diagnosis

21. ARE FINDINGS AND DIAGNOSIS CONSISTENT WITH PATIENT'S ACCOUNT OF INJURY OR ONSET OF ILLNESS?

Yes ☐ No ☐ If No, explain:

A. Did work cause or contribute to the injury or illness?

Yes ☐ No ☐ Cannot determine

If no or cannot determine, explain:

22. ICD9 Codes

8460

FILED 7A

Report Page 2

--- CONTINUED DOCTOR'S FIRST REPORT OF INJURY --- ANDERSON, JIM 494-94-944

Page 2 of 2

B. Is the patient permanent and stationary? ☐ Yes ☒ No If yes, Date: 11/03/99

C. If no, estimated permanent and stationary date: 11/03/99

D. Is permanent disability anticipated? ☐ Yes ☒ No

22. IS THERE ANY OTHER CURRENT CONDITION THAT WILL DELAY PATIENT'S RECOVERY? ☐ Yes ☒ No

If yes, say date. How many to same body part

23. TREATMENT RENDERED:

A. First Aid: ☐ Yes ☒ No

B. Treatment Date: OFFICE/OUTPATIENT VISIT, EST 10/17/99

D. Instructions to Patient: ERGONOMIC EDUCATION, HEAT AND LOW BACK EXERCISES

E. Referrals:

F. Disability status: Discharged as cured, with no need for further medical care? ☐ Yes ☒ No

G. If discharged, Discharge Date:

24. IS FURTHER TREATMENT REQUIRED? ☒ Yes ☐ No

A. Medication: VICODIN

C. If Surgery, type:

D. Diagnostic Tests:

E. Estimated Duration of Treatment: 25 days

C. Recommended Referrals:

H. Treatment Plan, Other:

25. IF HOSPITALIZED AS INPATIENT, Give Hospital Name and Location: Date Adm: Mo Day Yr Ent Stay: Days

26. WORK STATUS:

A. Is patient able to Perform Usual Work? ☐ Yes ☒ No

B. If not, date when patient can return to Regular Work: 10/26/99

C. If not, date when patient can return to Modified/Restrictive work: 10/20/99

D. Restrictive: Specific functional limitations (range) and weight restrictions based on an 8 hour work day:

Key: (U) Usual, (S) Severe, (O) Occasional, (F) Frequent - 35%-60%, (C) Continuous - 67%-100%

Activity

Repetitive Bending

Lifting From Floor

Lifting From Waist

Lifting From Above

Lifting From Below

Lifting From Side

Lifting From Back

Lifting From Front

Lifting From Below

Lifting From Above

Lifting From Side

Lifting From Back

Lifting From Front

Lifting From Below

Lifting From Above

Lifting From Side

Lifting From Back

Lifting From Front

Lifting From Below

Lifting From Above

Lifting From Side

Lifting From Back

Lifting From Front

Lifting From Below

Lifting From Above

Lifting From Side

F. Is employee likely to become a Qualified Injured Worker? ☐ Yes ☒ No

27. Doctor's Name and Degree: CLIFF L. WILSON, MD

Address: 121 TAYLOR ST., LAFAYETTE, CA 94508-8880

PPO Network:

IRS #: 393934481

CA License #: CA238192483

Specialty: OCC MED

Doctor's Telephone #: 925-384-8305

---DOCTOR'S SIGNATURE ON FILE AT DOCTOR'S OFFICE---

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or delaying worker's compensation benefits or payments is guilty of a felony.

Printed Name: CLIFF L. WILSON, MD
Signature: [Signature]

Input Form

Claims Verification Service - Microsoft Internet Explorer

File Edit View Go Favorites Help

Back Forward Stop Refresh Home Search Favorites History Channels Fullscreen Mail Print

Address http://216.103.197.67/stellarnet/patient/claimVerInput/claim_form.asp

Links [Best of the Web](#) [Channel Guide](#) [Customer Links](#) [Internet Explorer News](#) [Internet Start](#) [RealPlayer](#)

e-Stellarnet

Claims Verification Service

Enter Patient details (All fields are required.)

[Click here for batch verification.](#)

| | | | |
|-------------|--|------------------|---|
| Last Name : | <input type="text" value="SMITH"/> | First Name : | <input type="text" value="Sue"/> |
| SSN : | <input type="text" value="565340665"/> | Date of Injury : | <input type="text" value="10-24-1999"/> |
| Employer : | <input type="text" value="Railway Express"/> | Payer Name : | <input type="text" value="CSSG"/> |

[Back](#) [Home](#) [OpenMail](#)

Start [Inbox](#) [Miscell.](#) [System](#) [busine...](#) [Claim](#) [Explor...](#) [Micros...](#) [Paint S...](#) [duty](#) [Internet zone](#) 10:15 AM

FIGURE 8 A

Result Page

Claims Verification Service - Microsoft Internet Explorer

File Edit View Go Favorites Help

Back Forward Stop Refresh Home Search Favorites History Channels Fullscreen Mail Print

Address: http://216.103.197.67/stellarnet/patient/claimVetInput/Display_details.asp

[Best of the Web](#) [Channel Guide](#) [Customer Links](#) [Internet Explorer News](#) [Internet Start](#) [Read Page](#)

e-StellarNet

Claims Verification Service

Patient details

Last Name: SMITH

SSN: 565340665

Employer: Railway Express

Payer Name: CSSG

Status: ☒ Accepted ☐ Rejected ☐ Delayed

First Name: Sue

Date of Injury: 10/24/99

Claim Number: CA334848399

Payer ID: WCO34

[Click here to perform another lookup.](#)

[Back](#) [Home](#) [Demo Menu](#)

Start [File](#) [Edit](#) [View](#) [Go](#) [Favorites](#) [Help](#)

[Exploring .stel...](#)

[Inbox: Outlook...](#)

[claim Verificat...](#)

[Business Intr...](#)

[Microsoft Acc...](#)

[Claims Verif...](#)

Internet zone

FIGURE 8B

Alert Email

E-STELLARNET EARLY CLAIMS ALERT!-----TEST MAIL-----

File Edit View Tools Compose Help

Print Forward Reply Reply All Delete Move Copy Paste Undo Redo Find Print Setup

From: support@estellarnet.com

Date: Saturday, December 04, 1999 1:22 AM

To: SUNNY@CSWL.COM

Subject: E-STELLARNET EARLY CLAIMS ALERT!-----TEST MAIL-----

Date : 12/3/99

Last Name : BOYD

First Name : JOSEPH

Social Security : 554117231

Date of Injury : 04/27/99

Employer : MCMILLAN TECH

Payer : CMMC

Start

Stop

Print

Forward

Reply

Reply All

Delete

Move

Copy

Paste

Undo

Redo

Find

Print Setup

Home

Inbox

Outbox

Deleted

Compose

Tools

Help

Microsoft

Demo

daily

WIN

E-STE...

888

11:58 AM

FIGURE 8C

Inquiry Email (Form)

e-StellarNet

Provider Payment Status Inquiry Email

An email will be sent to **SUNNY@CSWL.COM** in the following format

Medical Payment Status

Date : 12/6/99

From : Sunny Paul(sunny@cswl.com)

RE: Employee Name: BOBO NEIL

Employer Name: MARINE WORLD

Claim No: 610061029996195

SSN: 389705260

Date of injury: 7/22/95

Please advise status on the following invoice:

Date of Service: 10/1/99

Account/Invoice no: 7A9832

Provider Name: Dr. KEN ANDERSON

Provider TIN: CA1798321

Date of Invoice: 10/1/99

Bill Control Number: CNDAC10932

Comments : Thank you for your help

Send it Cancel

Back Home Demo Menu

Received Email

Provider Payment Status Inquiry

File Edit View Tools Response Help

From: Sunny Paul

Date: Monday, December 06, 1999 8:14 PM

To: SUNNY@CSWL.COM

Cc: sunny@cswl.com

Subject: Provider Payment Status Inquiry

MEDICAL PAYMENT STATUS

Date: 12/6/99

From: Sunny Paul(sunny@cswl.com)

Re: Employee Name : BOBO NEIL

Employer Name : MARINE WORLD

Claim No : 610061029996195

SSN : 389705260

Date of Injury : 7/22/95

Please advise status on the following invoice :

Date of Service : 10/1/99

Date of Invoice : 10/1/99

Account/Invoice no : 7A9832

Provider Name : Dr. KEN ANDERSON

Provider TIN : CA1798321

BILL CONTROL NUMBER : CMMC10932

Comments :

Thank you for your help

Click

<http://www.e-stellarnet.com/application/indemail/response.asp?rdn=112>
to reply to this mail

Start | Stop | Print | Copy | Paste | Undo | Redo | Mail | Address Book | Favorites | Tools | Help | 12:17 PM

Response Form

e-StellarNet

Provider Payment Status Inquiry - Response Email form

To Medical Facility : sunny@cswt.com

Bill Control No.(BCN) : CMMC10932 (For future reference please use the above BCN)

The status of above Invoice is:

- ☐ Our records indicate payment was released on 10/28/1999
- ☐ Our records indicate payment was paid in accordance with our contract agreement.
- ☐ No further payments are recommended
- ☐ Claim is currently under review for medical necessity
- ☐ Claim is currently under AOE/COE investigation.
- ☐ Claim was denied
- ☐ Necessity for this service is currently under review.
- ☐ No Policyholder Under This Name.
- ☐ We do not have coverage for this employer for this Date of Injury.
- ☐ No Industrial Injury Reported By Employer.
- ☐ Doctor's First Report Needed.
- ☐ Current Medical Report Needed.
- ☐ Itemized Statement Needed.
- ☐ Other _____

Next Page Reset

Black Box (Form 10/19/99)

Response Email

Provider Payment Status Inquiry - Response Email

File Edit View Tools Compose Help

From: SUNNY@CSWL.COM
To: sunny@cswl.com
Cc: SUNNY@CSWL.COM
Subject: Provider Payment Status Inquiry - Response Email

Date: Monday, December 06, 1999 8:22 PM

Bill Control No.(BCN) : CMMC10932

Account/Invoice no : 7A9832

Provider Name : Dr. KEN ANDERSON

Date of Service : 10/1/99

Claim Number : 610061029996195

Date of injury : 7/22/95

SSN : 389705260

Employee Name : BOBO NEIL

The status of above invoice is:

Our records indicate payment was released on 10/28/1999.

SUNNY@CSWL.COM

Workers Compensation Medical Billing unit

Start | End | In | Out | M | T | W | Th | F | Sa | Su | Mon | Tue | Wed | Thu | Fri | Sat | Sun | 12:25 PM

FIGURE 9 D

Stellar Net Home Page



StellarNet®

*Internet solutions for the
workers' compensation community*

- Home
- Registration
- Submit Bills
- WC Program
- Information
- New Members
- Press Releases

The steps to secure Internet processing of claims/bills & workers' compensation (WC) reports are as easy as 1, 2, 3. Register today & get control of the Paper Tiger!

| TO DO THIS (using SSL? GO HERE) | RESULTS |
|--|--|
| 1 Register on-line to submit bills and workers' compensation reports. | Registration You will receive an email confirming your registration & instructions on how to get started submitting bills |
| 2 After receiving email confirmation & instructions, submit bills from existing medical billing software. | Submit Bills After bill submission, you will get an acknowledgement within 48 hours for your first submission, within 24 hours thereafter |
| 3 After receiving email confirmation & instructions, download workers' compensation programs & instructions. | Download WC Programs After you download the WC programs, a key will be sent that permits you to unlock the programs & use them |
| • SSL-Secure Socket Layer encryption | Secure transmission of data |

Click below for additional information:

- [Fees](#)
- [Terms and Conditions](#)
- [Privacy Policy](#)
- [Description of 1500 Data Elements](#)
- [Description of Bill Submission & WC Medical Reporting](#)
- [Payer Information & List of Electronic Payers/Receivers](#)
- [Provider Information](#)
- [Minimum System Configuration](#)
- [Glossary](#)
- [Demonstrations](#)

Other Features:

FIGURE 10A

FIGURE 10A: StellarNet Home Page. The StellarNet Home Page is the central hub for all StellarNet services. It provides information on the company, its services, and how to contact them. The page is designed to be user-friendly and easy to navigate.

StellarNet On-Line Bill Submission Form

e-StellarNet[®] On-Line Bill Submission

Welcome to StellarNet's on-line bill submission page. Please complete the form:

1. If you are not registered, [click here to go to registration page.](#)
2. Registered members, proceed with bill submission:
 - a. Input your email address in the first box and click on "Report" to double check your membership status. If you are not registered, or if the email address is incorrect, you will get an error message.
 - b. To submit your bills use the "Browse..." button to select the name and location of the file(s) to submit. You can submit up to 3 files at one time.
 - c. To submit the bills, click "Upload file(s)!" to submit bills

If you are a first time submitter, you will receive an acknowledgement back within 48 hours after you have submitted your first batch of bills. Thereafter, you will receive the acknowledgement back within 24 hours of submitting your bills.

Please press the TAB key NOT the ENTER key to move down. Use Shift TAB to move up.

Member
Upload
Password or
Email:

Files To Upload:

| | | |
|---|----------------------|---|
| File 1: | <input type="text"/> | <input type="button" value="Browse"/> |
| File 2: | <input type="text"/> | <input type="button" value="Browse"/> |
| File 3: | <input type="text"/> | <input type="button" value="Browse"/> |
| <input type="button" value="Upload File(s)"/> | | <input type="button" value="Reset Form"/> |

Use browser's BACK button to return to previous page.

If you have any questions...

Call us at 415/882-5700, or Email us at rtvfast@ibm.net

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FILE TO B

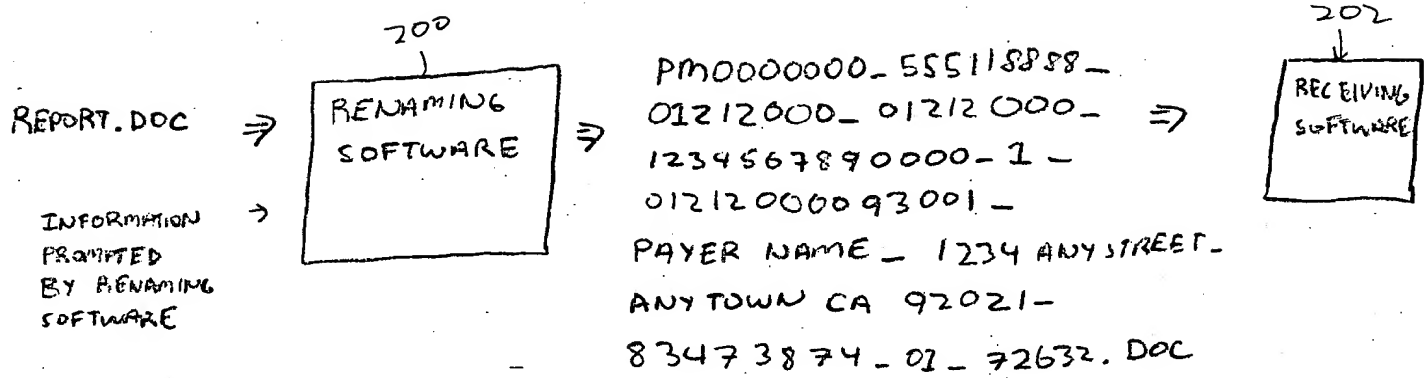


FIGURE 11

| Field Name | Len | Type | Description / Example |
|--------------------------|-----|------|--|
| Payer ID | 9 | Char | Electronic payer ID example: WACA02012. Print and mail payer ID is always PM0000000. |
| Patient's SSN | 9 | Char | Example: 123880000 |
| Date of Injury | 8 | Char | MMDDYYYY Jan 20, 2000 example: 01202000 |
| Date of Service | 8 | Char | MMDDYYYY Jan 21, 2000 example: 01212000 |
| Type of Service | 1 | Char | 1=Medical Care, 2=Surgery, 3=Consultation, 4=Diagnostic X-ray, 5= Diagnostic Laboratory, 6=Radiation Therapy, 7=Anesthesia, 8=Assistance at Surgery, 9=Other Medical Service, 0=Blood or Packed Red Cells, A=Used DME, F=Ambulatory Surgical Center, H=Hospice, L=Renal Supplies in the Home, M=Alternate Payment for Maintenance Dialysis, N=Kidney Donor, V=Pneumococcal Vaccine, Y=Second Opinion on Elective Surgery, Z=Third Opinion on Elective Surgery. |
| Provider Tax ID + Sub ID | 13 | Char | 1234567890000 (use 0000 if not using sub ID) |
| Submit Date and Time | 12 | Char | MMDDCCYYHHMMSS Jan 22, 2000 9:30 01 am example: 01222000093001 |
| Payer Name | 25 | Char | ABC WC PAYER |
| Payer Address | 25 | Char | 100 MAIN STREET |
| Payer City State Zip | 25 | Char | BIG CITY NY 00030 |
| Claim Number | 28 | Char | 20303200223 |
| Type of Document | 2 | Char | 01=First Report, 02=Supplemental Report, 03=P&S Report, 04=QME, 05=Consult, 06=AME, 07=Entire File, 08=Diagnostic, 09=Chart Notes, 10=Pre-Authorization Request, 11=Referral Request, 12=Disability Status, 13=Surgical, 14=Ambulance, 15=Ancillary, 16=Home Care, 17=Other |
| ICD9 | 6 | Char | Primary Diagnosis Code, no spaces no period on 5 digit codes. |
| Period | 1 | Char | . (also known as dot) |
| File Type | 3 | Char | Original file extension, DOC, RTF, TXT, etc. |

FIGURE 12

E StellarNet Report Upload Site - Netscape

Location: <http://www.stellar.net.org/html/en-reports.html>

On-Line WC Reports and Attachments Submission

Welcome to e-StellarNet's on-line report submission page. Please fill out this form completely for quick delivery to the proper administrator. [Democratization](#)
If you are not registered, [click here to register](#).

Please press the TAB key NOT the ENTER key to move down. Use Shift TAB to move up.

Member Upload Password or Email:

Locate Local Zip File of All Attachment Files or
Single Attachment File to Upload

Only fill out these following fields if
sending a single, non-zipped, attachment file.

Payer ID

Patient Social Security No

Date of Injury

Date of Service

Provider Tax ID

Type of Service Code

Your Initials and ID

Use browser's BACK button to return to previous page.

Document Done

FIGURE 13